



# South Carolina Department of Insurance

Division of Consumer, Licensing and Legal Services  
Office of Special Services  
300 Arbor Lake Drive, Suite 1200  
Columbia, South Carolina 29223

MARK SANFORD  
Governor

ELEANOR KITZMAN  
Director of Insurance

Mailing Address:  
P.O. Box 100105, Columbia, S.C. 29202-3105  
Telephone: (803) 737-6134

## MEMORANDUM

TO: ALL LICENSED UTILIZATION REVIEW ORGANIZATIONS/ PRIVATE REVIEW AGENTS

FROM: DIRECTOR OF INSURANCE OF SOUTH CAROLINA

SUBJECT: Procedures for Continuation of Utilization Review / Private Review Agents' Certificate Licensing period of 2006-2008

Pursuant to Code Section §38-70-30 and S.C. Regulations 69-47 (H)(3)(A), your current Utilization Review Certification is due to expire on June 30, 2006. Attach is the renewal application (**Form 2510**) which must be properly completed and returned to this Department by June 30, 2006, with applicable license fees (\$800 dollars). To ensure that there will be no lapse between the issuance of your new certificate and the expiration of the current certificate, please follow the instructions below:

- Section 1.** List major owner(s) and percentage or ownership if organization type is corporation or partnership.
- Section 2.** Provide state of incorporation if organization is a corporation. (Attach a copy of Certificate of Authority, Letter of Good Standing, and Articles of Incorporation)
- Section 3.** List other location of the organization
- Section 4.** List all partners or officers (attach a separate sheet, if necessary)
- Section 5.** Provide hours of operation and toll free number

In addition, submit a copy of your "Utilization Review Program" with the renewal application.

- Provide an accessibility plan of operation for weekends and holidays.
- Provide both a list indicating the total of all reviewing personnel, by specific qualification or specialty. Additionally, include a total of all physicians, by specialty, which support and/or supervise reviewing personnel.
- Provide the total number of covered lives for which the reviewing personnel of your company may be required to perform utilization review activities.
- Provide a copy of all materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under each contract.
- Provide the applicants procedures for notification of an adverse decision. Include all forms used in adverse decision notification process.
- Provide the applicants appeal procedures by which insured and providers may seek reconsideration of determinations by the applicant's utilization review personnel. Include all appropriate forms used within the appeals process.
- Provide the applicants internal procedures currently in place to protect the confidentiality of individual medical records.
- Specifically list all state and federal laws, which were reviewed by the applicant to develop these procedures.

**Incomplete filings cannot guarantee issuance of new certificate. Failure to complete your renewal by June 30, 2006, will prevent your organization from performing utilization reviews in this state.**



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## APPLICATION FOR RENEWAL OF UTILIZATION REVIEW FOR THE LICENSING PERIOD JULY 1, 2006 THRU JUNE 30, 2008.

Company Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Company Code: \_\_\_\_\_  
Type Organization: \_\_\_\_\_

Contact: \_\_\_\_\_

Business Phone No: \_\_\_\_\_

THE RECORDS OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE REFLECT THAT YOUR ORGANIZATION IS CURRENTLY LICENSED AS AN UTILIZATION REVIEW PURSUANT TO THE REQUIREMENT OF S.C. CODE ANN. 38-70-30 AND S.C. REGULATIONS 69-47 (H) (3) (A). YOUR CONTINUATION LICENSE FEE IS \$800. PLEASE MAKE YOUR CHECK PAYABLE TO SOUTH CAROLINA DEPARTMENT OF INSURANCE. THIS APPLICATION MUST BE COMPLETED AND RETURNED TO THIS DEPARTMENT ALONG WITH ALL OTHER REQUIRED ITEMS NO LATER THAN **JULY 1, 2006**.

### SECTION I – LIST MAJOR OWNER AND PERCENTAGE OR OWNERSHIP IF ORGANIZATION TYPE IS CORPORATION OR PARTNERSHIP (Attach a copy of the partnership agreement if applicant is a partnership)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### SECTION II – PROVIDE STATE OR INCORPORATION IF TYPE ORGANIZATION IS A CORPORATION (Attach a copy of Certificate of Authority, Letter of Good Standing, and Articles of Incorporation from State of Incorporation)

State of Incorporation: \_\_\_\_\_

### SECTION III – LIST OTHER LOCATIONS (Attach a separate sheet if necessary)

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE #
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

### SECTION IV – LIST ALL PARTNERS OR OFFICERS (Attach a separate sheet if necessary)

NAME	SOC. SEC. NO.	BIRTH DATE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

### SECTION V PROVIDE APPLICANT'S HOURS OF OPERATION WITHIN THE STATE OF SC

(EASTERN STANDARD TIME): \_\_\_\_\_  
(TOLL FREE NUMBER): \_\_\_\_\_  
(NUMBER OF INCOMING TELEPHONE LINES): \_\_\_\_\_  
(INCOMING CALL QUEUE TIME): \_\_\_\_\_

### APPLICANT'S SWORN STATEMENT

I do solemnly swear that all information contained within this application, is complete, true, and correct to the best of my knowledge. Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_

Signed \_\_\_\_\_

Title \_\_\_\_\_